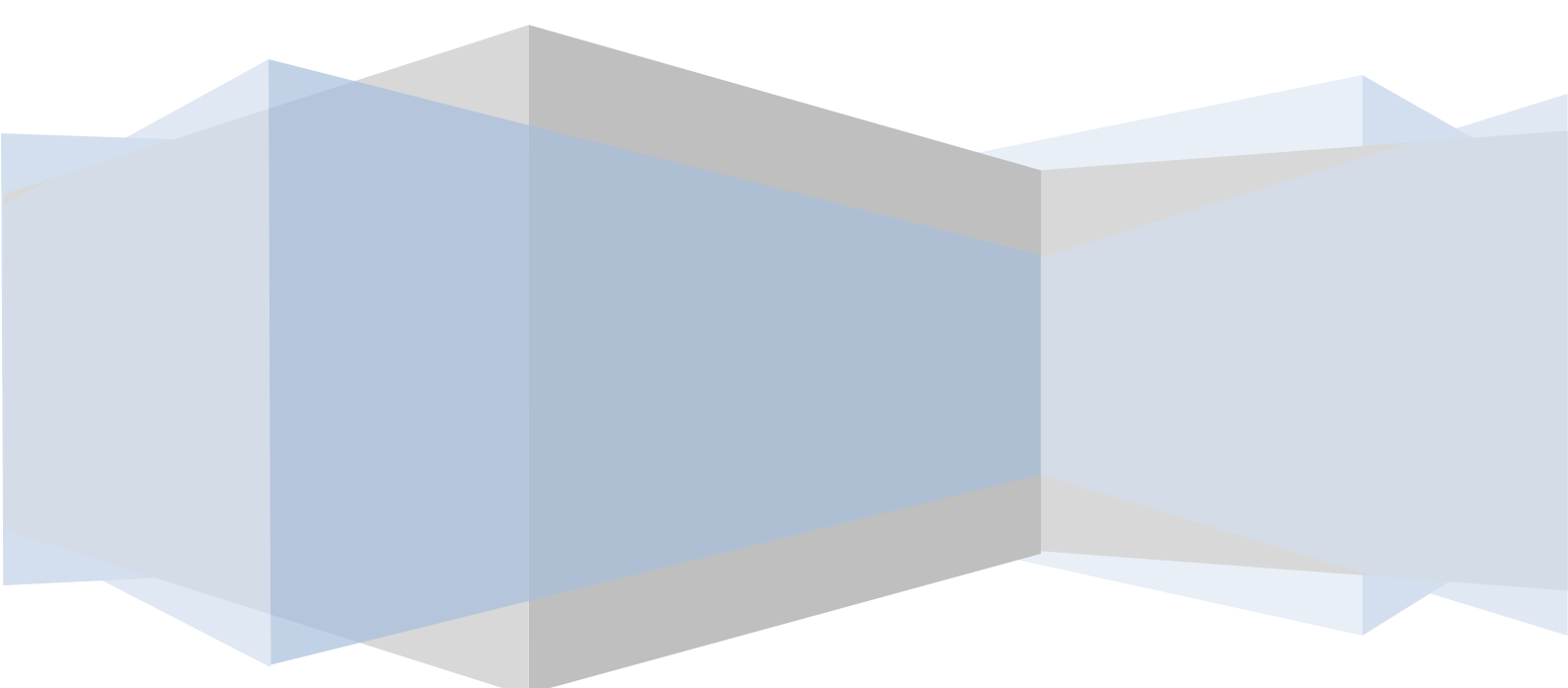




Glasgow City

Primary Care Improvement Plan (PCIP 2) 2019-21

May 2019



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Section 1: Background

In 2017/18 agreement was reached by the Scottish Government and Profession on the new GP contract. The Primary Care Implementation Plans (PCIPs) are intended to explain how this will happen in each HSCP area over a three years period from April 2018 and is supported by additional funding for four years from the Scottish Government.

The initial three year period will be phase 1 of the process and the Government and British Medical Association have agreed to develop plans for a second phase, which will be subject to another poll of GPs in 2020.

The contract for 2018-21 is supported by a Memorandum of Understanding (MoU) agreed between the Scottish Government, the British Medical Association, Integration Authorities and NHS Boards. The MoU identifies six priorities for reducing the workload of GPs as part of the broader plan for sustaining primary care services. These priorities are:

- Vaccination services
- Pharmacotherapy services
- Community treatment and care services
- Urgent care services
- Additional professional services, including acute musculoskeletal physiotherapy services, community mental health services
- Community link worker services

In September 2018 the IJB approved the first PCIP for Glasgow City for submission to the Scottish Government and agreed to provide further updates (PCIP 1). Implementation of PCIP 1 has proceeded and progress and future plans are reported for each of the priority work streams. The PCIP 2 will provide a summary of progress during 2018/19 and plans for 2019/20 and later years.

In February 2019 the Scottish Government issued further guidance, appendix 5.1 and requested submission of an updated PCIP 2 from each partnership, agreed with the local GP Sub Committee. The new guidance places emphasis on specific themes and progress and plans relating to these are reported below.

The Scottish Government is also seeking completion by partnerships of a tracker every six months summarising progress since July 2018 and setting out scheduled spend and recruitment. The tracker is included as appendix 5.2 and is referenced in the body of the report.

Section 2: Approach to Implementation

In view of the scale and complexity of the task in a partnership with 146 practices and 21 clusters, it was considered more desirable and practical to devolve implementation to the three Glasgow City Localities (North East, North West and South) where there are already close working relationships between HSCP staff, Cluster Quality Leads (CQLs) and other key stakeholders.

The devolved approach was supported over the course of two engagement events held in September 2018 attended by over 100 of the 146 practices. With the HSCP, by way of the PCIP Implementation Leadership Group (ILG), retaining overall leadership of planning, financial management and co-ordination of implementation at a city level the devolved approach maximises local planning, choice and decision-making and ensures that the deployment of investment fits best with GP preferences as well as increasing effectiveness and matching local needs and circumstances.

During 2019/20 it is expected that these devolved arrangements will mature, they will be informed by a series of workstream briefings and information on existing primary care resources to better fit the different circumstances and operating arrangements in each Locality, cluster and practice. By understanding the different operational management arrangements the availability of existing services and resources, as well as the diversity of GP views and their experiences of the most effective interventions to make biggest impact on GP workload, we will be better placed to collaborate in Localities on the most effective way to deploy the additional resources.

As the devolved implementation arrangements bed-in it is envisaged that a product of this will be a progressive exercising of greater influence by primary care practitioners on the delivery of city and Board wide plans and services within their local areas e.g. Vaccination Transformation Programme and treatment and care services, the adaptation of promoted models of care such as physiotherapy and the shaping of locally relevant responses for priorities like mental health.

The aim during this financial year is to keep GPs at the forefront of the evolving proposals, ensuring that engagement with GPs across the city and their influence on the programme is maximised in readiness for the significant increase in the PCIF allocation in 2020/21.

SECTION 3: Workstreams Progress and Plans

3.1 Vaccination Transformation Programme (VTP)

Within PCIP 1 there are five programmes of vaccination delivered by GPs and HSCP staff and the new GP contract envisages that ultimately current responsibilities held by GPs for these programmes will be transferred to the HSCP. The Vaccination Transformation Programme (VPT) is coordinated at a Board level, and progress has been variable for these programmes as a result of the lack of availability of IT systems for call and recall and data sharing arrangements between practices and the wider system. Detailed below is progress and future direction for the five programmes;

Pre 5 Routine Immunisations Programme

Routine child immunisation has been coordinated at Board wide level with a move from being delivered in 239 practice settings to 39 (out of a total of 40) community clinics; there has been a delay in the final clinic due to accommodation problems.

2 to 5 year old Flu Vaccination Programme

The implementation of the pre-school flu programme has not been achieved yet due to the level of clinical risk associated with the inability to find safe solutions for call and recall and data sharing. There is a plan for 2019/20 using bank staff over 10 weeks from October to November 2019 and the VTP Programme Board is considering a joint approach with adult community clinics.

School Immunisation Programmes

School age immunisations continues to be delivered by HSCP staff through a dedicated team for the whole of the Board area that is hosted by the North West Locality. They will also cover flu vaccination for school age children.

Adult Immunisation (Pneumo, Flu and Shingles)

Adult vaccinations is an extensive programme which is both age and risk based covering flu, shingles, pneumococcal and the pertussis vaccine for all pregnant women. With progress being made at variable rates across the VTP programme as follows:

- A service model has been agreed for the immunisation of pregnant women for pertussis and flu and is to be delivered by Maternity Services in 2019/20 with ongoing work required for IT / data to support a call and recall system and data sharing.
- A programme for under 65s 'at risk' flu has not been established as we do not have a suitable IT system. A local model will need to be developed because of the lack of progress in the commissioning of a national system.
- The over 65's flu vaccination elements is supported by the ready identification of patients through CHI and for those who are housebound this was delivered by HSCP district nursing team in 2018/19. The plan is to repeat this in 2019/20 and to extend this element to encompass the shingles vaccines. The latter has not been possible due to the need for robust data sharing

arrangements given the clinical risks due to the live nature of the shingles vaccine.

- In 2019/20 a gap analysis of adult/older people's services will be undertaken with the requirement to negotiate the cost of the service provision with the community pharmacy sector in 2019/20 and consideration to additional costs for IT/Data and Pharmacy resource for 2020/21.

Travel Vaccination and Health Advice

Travel vaccines and health advice dependant on the national options' appraisal exercise that is being led by Health Protection Scotland to provide clarification of the scope of the programme.

3.2 Pharmacotherapy

The MoU provides a commitment that by 2020/21 HSCPs will deliver the pharmacotherapy commitments of the new GP contract with pharmacotherapy service being established in every GP Practice. PCIP 1 estimated Glasgow would require between 178 and 229 additional wte staff to deliver the full requirements of the contract but explained that this would be unachievable, given the challenges with recruitment of qualified staff, the constraints on our funding and our capacity to put in place the management and supervision arrangements for such a large cohort of new employees. Therefore in PCIP 1 we proposed to adopt the model developed by Inverclyde HSCP that would require us to recruit an additional 90 pharmacotherapy staff based on the ratio of 2:1 pharmacists to technicians.

Progress 2018/19

In 2018-19, we recruited staff to 17.9 wte to reach 36.5 wte covering 43 practices and 18 clusters in the city.

Action 2019/20

Short supply of skilled qualified staff remains the biggest single obstacle to implementation and requires urgent national action to address this issue. In 2019/20, at current supply rates it is projected that the pharmacotherapy workforce will only grow six monthly by around 10 additional staff. It is expected that this rate of growth will continue into 2020/21 and 2021/22. On this basis of this trajectory implementation at 0.5 wte per 15,000 patients will not be achieved until 2022/23.

We continue to explore how delivery of the contract can be achieved by 2021/22. Short of reducing the level of input to one day from the present two days per 5000 registered list size, a range of options are being explored, these include;

- Adjusting skill mix by increasing the proportion of technicians in the pharmacy workforce from the current 12% to closer to the national average of 28%. Tests of change of optimal skill mix, including pharmacy support workers will be undertaken during 2019/20.

- Greater use of the wider pharmacy workforce with tests of change in 2019/20 to scope out how many of the tasks could be delivered by community pharmacists.
- Developing the workforce pipeline in 2019/20 with additional capacity for education and training for student pharmacy technicians and recruitment of junior pharmacists.
- Scoping of digital/remote working solutions to reduce duplication and increase efficiency by a more integrated approach to tasks, such as medicines reconciliation.

The estimated cost of the pharmacotherapy programme may require to be increased. As well as staffing, further cost pressures are the cover for holidays, illness and maternity leave, administrative support and leadership capacity for the professional development of a growing workforce. Amongst current constraints are available space, GP capacity for mentoring and staff turnover.

3.3 Community Treatment and Care Services

The new GP contact requires community treatment and care services to be in place by April 2021. In NHSGGC we agreed that this workstream would be coordinated by a Board wide community treatment and care service development group and this group has agreed a work plan for 2019/20.

Progress 2018/19

In 2018/19 the provision of phlebotomy services was prioritised as phase 1 of the development of community care and treatment services, with the appointment of a Team Lead and 11 wte phlebotomists working from existing treatment rooms. This service became operational in November and will investigate the feasibility of delivering phlebotomy services from other settings.

Based on work by Renfrewshire HSCP, the estimates of the number of phlebotomists required to provide a full service for all GP practices has been raised to 90 wte. As well as staffing there requires to be consideration of administration and management costs. For 2019/20 developments will focus on the upgrading and equipping of additional clinical space, a rolling recruitment programme managed at Board level, an increase in IT equipment and licences, domiciliary and mobile solutions and continued engagement with clusters as the roll out progresses.

As with phlebotomy, the full care and treatment service model is being developed at a Board level. Based on these plans community treatment and care services in the city will double in size with the proposed recruitment of 30-35 wte treatment room staff in each of the next two years together with administration and the introduction of the required leadership capacity. Our ability to upscale the treatment room service will depend on the availability of an appropriate workforce and obtaining sufficient premises and we are proposing to take forward a test of change in 2019/20 to investigate what we need to do to achieve full implementation of the model.

The availability of accommodation remains one of the main issues to be addressed with business cases being prepared for some locations in the city and will include the consideration of alternative properties and models of delivery such as mobile units.

Action 2019/20

The plan for 2020/21 for Phlebotomy is to review demand, capacity and resource, complete recruitment, implement a full service including domiciliary and to scope secondary care demand. It is now clear that to complete the plan for phlebotomy and community treatment and care services for the city, including the introduction of the necessary leadership capacity will significantly increase the projected budget required from the overall allocation (see 4.5).

In 2019/20 our priorities for treatment rooms will be the focus on creating sufficient clinical space, a rolling recruitment programme, the introduction of nurse prescribing and self-referral for some conditions (e.g. ear irrigation), which will continue into 2020/21 to a full range of interventions. Other issues that have emerged and are being considered include; local versus board wide approaches to delivery of the service, balancing what has been in existence with the development of new areas of service and implementation of the EMIS (IT) system.

3.4 Urgent Care

PCIP 1 noted that GPs in the city were not attracted by the urgent care model adopted in Inverclyde new ways pilot, which used paramedics or Advance Nurse Practitioners (ANPs) for urgent home visits. Glasgow City GPs did recognise, though, the shift in urgent care towards community and primary care with increasing complexity of care for those people who are managed at home and in residential and nursing home settings. In respect of residential and nursing home settings, GP's indicated that there could be potential to reduce their workload by providing support in these settings.

Progress 2018/19

During 2018-19 a service model was developed that would employ 3.6 wte Band 7 ANPs to work alongside existing district nursing input to reduce the need for unscheduled GP visits to patients in local authority residential care units. The ANP's will exercise a high level of clinical decision making, with key roles in clinical assessment, differential diagnosis, prescribing, investigations and treatment. Two practitioners will take up post following their induction in April 2019 to join the existing 1.6 wte.

Action 2019/20

In 2019-20 the impact of the ANP residential care service will be evaluated and modified if required before it is considered for wider implementation. In addition the consequences for GP day time services will be considered as part of the process to implement the multi-disciplinary urgent care hub in the city that is being developed

as part of the out of hours review undertaken, as well as responding to the wider agenda around unscheduled care.

Two further areas of associated activity under this workstream are

- Raising awareness of the 'Knowing Who To Turn To' publicity materials
- Supporting practices to improve the management of unscheduled care through adopting work flow efficiency and care navigation approaches.

All of these elements will be taken forward with GPs through Locality work with clusters to identify local preferences and support from GPs, though this may extend into 2020/21 to build the full programme.

3.5 Community Link Workers

PCIP 1 outlined how we would deliver the national programme to increase the number of Community Link Workers (CLWs) within those practices serving some of the most deprived patient populations. The use of CLWs delivered by third sector organisations increases capacity for social prescribing and infrastructure e.g. carer centres and community connectors within GP practices.

Progress 2018/19

In 2018/19 a public procurement process was completed to increase the numbers of CLWs in the city for the lifespan of the PCIP from 17 CLWs to 35 CLWs the end of 2019/20.

As a result of the procurement process the Health and Social Care Alliance was identified as the preferred supplier. The Alliance will continue to employ CLWs and secure the additional workforce with the requirement to go out to mini competition to provide CLWs for additional clusters when these are known. Innovatively the procurement process was undertaken in collaboration with staff in clusters (GPs and others). The on-going growth and development of the model will be supported through the appointment of a health improvement lead.

Based on the original intention that, nationally, CLWs would be deployed in the more deprived areas, we estimate that to achieve this aspiration, Glasgow city will require 70 CLWs covering 80 GP practices in the cities with the most deprived areas. There is, therefore, an ongoing dialogue with the Scottish Government to establish a funding allocation for CLWs that reflects the substantial health inequalities of Glasgow's population.

Action 2019/20

In 2019/20, as well as the focus on our negotiations with Scottish Government to increase the number of posts, we will review the current model to ensure that it meets the needs of smaller practices. We will investigate how best to implement the model into practices, development of the thematic themes of CLWs for youth health, community justice and asylum seeker and refugee communities and progress the

monitoring and evaluation work. This requires infrastructure to support suppliers including workforce development, shared learning sessions between CLWs and practices while connecting the CLW programme with other community orientated programmes operating in primary care that support patients and communities. Future upscaling of the CLW programme in 2020/21 will be dependent upon the outcomes of the ongoing discussions and developments with the Scottish Government.

3.6 Mental Health

PCIP 1 recognised this area as a significant component of GP workload in which patients presenting with low mood, anxiety and depression would often be unable to have their issues fully resolved by the GP, thus resulting in an outcome whereby patients keep returning for help. PCIP 1 acknowledged that significant scoping work would require to be undertaken to better understand the complexity of existing pathways and therefore the most effective way to add value from any additional resources. The primary care mental health response should be part of whole system response, support the principles of trauma informed practice and build on tests of change to inform the way forward.

Progress 2018/19

During 2018/19 attention focused on defining what was in scope in terms of the pressures faced by GP practices associated with patients mental health and mental well-being issues. This identified what might constitute an effective range of support and self-help resources for patients that could be provided beyond the GP surgery, as well as improved access to specialist mental health services when required. Together this provides the correct response for patients, takes workload from GPs and improves communication between the network of mental health services. The mental health briefing paper that is being developed for use in Localities comprises four main elements

- A mental wellbeing model addressing complex social morbidity presentations
- Designing a more comprehensive primary care response for patients presenting with low mood, anxiety and depression
- Examining the pathways from practices in and through specialist mental health services
- An acute distress response linked to work on unscheduled care, with the distress collaborative and out of hours urgent care hub

Recognising the feedback from GPs that many of their patients suffer from stress and distress as a consequence of their life circumstances, during 2018/19 funding was approved for a number of projects which would address some of issues being faced by patients. These were continuation of funding for Lifelink services and financial inclusion services embedded in a number of GP practices for a further twelve months. Funding for two years was approved to extend the youth health services delivered in North West to North East and South.

Action 2019/20

Over the course of 2019/20 it is expected that the briefings referred to above will progressively inform collaboration between GPs and HSCP staff and other stakeholders in each Locality and enable them to identify what resources are currently available in the local area and to determine what further resources would bolster and extend local infrastructure. This approach will underpin the selection of areas for tests of change in each Locality.

It is anticipated that discussions will consider shared learning of what exists and works in other areas, future use of existing resources like Lifelink and Primary Care Mental Health Teams. This will include an appreciation of the contribution that related services, such as Youth Health service hubs also make as well as the development of current small scale initiatives which have evaluated well such as financial inclusion and attached addiction nurses embedded within practices. The three Localities will be invited to identify a cluster(s) in which this composite approach can be tested.

The ongoing Locality discussions and the learning from the tests of change in 2019/20 will set the agenda for investment and development in the subsequent years

3.7 Physiotherapy

PCIP 1 that in order to meet the requirements of the contract, we estimated that we would need 51 wte posts. These planning assumptions were based on a ratio of 1 wte physiotherapist for up to a maximum of 3 practices (patient population of 14,000 to 16,000 per wte post) with an average activity of 14 to 16 consultations per day.

Progress 2018/19

The implementation of the MSK physiotherapy recruitment is being planned on a phased basis. During 2018/19 we appointed a Clinical Lead and increased the number of Advanced Practice Physiotherapists (APP) to 6 wte covering 13 GP practices as part of multi-disciplinary teams with clinical capacity steadily increasing and we commenced data collection on the flow of patients through the service.

A significant number of our practices and Cluster Quality Leads have expressed reservations about ability of the current, MSK model to deliver the expected benefits in terms of ready access for patients, reduce MSK workload for GPs or being suitable for use with small practices. We therefore plan to evaluate the current model closely before we expand it any further. Plans to consider other models are under discussion with workstream oversight group.

We are also aware of the existing MSK services treatment performance in the city with only 41% of patients being seen within 4 weeks against a target of 90%. With the prospect of a significantly expanded workforce it is opportune to consider how we might improve the service as a whole to increase overall MSK access for patients.

The evaluation of the impact of the physiotherapist role in the Govan SHIP indicated that the patient profile using the service is very similar to the practice profile with a majority of service users from SIMD 1.

Action 2019/20

As a consequence of constraints on the supply of suitably qualified and experienced practitioners there will be a further recruitment of only 5 wte Advance Physiotherapy Practitioners (APPs), with an additional 5 wte and a team leader in 2020/21. With no significant change in the national supply of practitioners envisaged at this point, it is likely that this limited growth rate may continue.

In 2019/20 we will scope out what is required to deliver the plan on time and assess the ability of the current model to meet its objectives, this scoping out will include finalizing the budget needed, the appropriate skill mix of practitioners and how to meet needs of small practices. The pace of delivery is dependent on availability of clinical space and a skilled workforce with the need for national action to increase the number of graduates to meet the growing demand for this workforce. As well as consideration to the model for small practices consideration will be to the possible role of other Allied Health Professions in reducing GP workload.

3.8 Occupational Therapy

Following a successful test of change in NHS Lanarkshire where Occupational Therapy was developed within 2 GP practices and a substantive service has now been funded, consideration has been given to a similar model of service delivery in Glasgow with the delivery of a test of change in 2019/20. The service offers occupational therapy assessment and intervention to a diverse patient population aged 16+ with multiple long term conditions across the spectrum of both physical and mental health care to prevent functional decline, building resilience, enabling earlier return to work and keeping people safe to reduce the need for homecare and social services input. It is anticipated that the establishment of OTs within GP practice will reduce the burden on GPs. Based on Lanarkshire findings, 50% of patients had reduced GP appointments.

Action 2019/20

In 2019/20 a test of change is proposed in General Practice, initially within 2 practices in the one area for a 12 month period. If successful, this would extend to further practices in 2020/21.

3.9 Sustainability

PCIP 1 acknowledged the challenges currently being faced by city GP practices such as an ageing workforce, changing work patterns, demands and complexities of working in deprived areas and changing population demographics.

Although PCIP 1 intended to support the sustainability of the GP role and by extension GP practices, primarily by transferring workload and risks from GPs to a range of other practitioners and services, it is also committed to taking as proactive an approach as possible to the identification and addressing of sustainability challenges at an individual practice level. This increasingly systematic approach will build on existing work to ensure that all possible steps are being taken to identify and address practice sustainability issues.

Progress 2018/19

Actions taken in 2018/19 from PCIP 1 Include:

- Work with the SHIP and Pioneer project leads to develop an inclusive approach that incorporates learning from this experience, as well as other 'new ways' experience in the Board area for example, the New Ways work in Inverclyde.
- This has resulted in the drafting of a plan, currently out for consultation with colleagues in the three Localities in Glasgow City that proposes to test a more systematic and proactive approach to promoting the sustainability of primary care in Glasgow, that also fits with wider local (board) and national (Scottish Government) plans.

Action 2019/20

- Continuing the current sustainability working whilst testing more systematic and proactive approach to the identification of sustainability challenges for example combining our current intelligence with the offer of a proactive survey of all practices in one Locality.
- Strengthening support to practices could primarily take the form of ensuring that the wider supports are available to the practices in greatest need, examples of these include; multi-disciplinary team (MDT), workflow, administration support, training and other ways of meeting practice specific needs.
- Identify how Pioneer learning and legacy are taken forward under sustainability workstream.

Action 2020/21

- Evaluating the above 'systematic' Locality approach and rolling out a version that incorporates the learning from the test site across the other two Glasgow City Localities. The rolled out version would include plans for regularly updating our intelligence to the sustainability of practices in the city, as well as a continually evolving a set of responses to the issues that are identified.

3.10 Collaborative Leadership and Learning

Over the 2018/19 we have considered the collaborative thinking and leadership that are needed to develop the relationship skills to develop trust and respect to deliver on new ways of working. A leadership group has been set up to share learning

approaches to the changing issues arising from the PCIP to coordinate learning activity and to identify stakeholder engagement that will be necessary to support changes in values, attitudes and behaviours.

Progress 2018/19

During 2018/19 we reached agreement on the

- Principles of how we involve all the stakeholders at city wide and locality levels,
- Where and how decisions will be made on expenditure of the PCIP
- Provided clarity on where decisions are fixed because workstreams are being developed at a Board or city level and where flexibility can be given to the three localities and clusters to decide how the resources will be deployed
- How this work links to the role of clusters, while identifying the support for induction and development.

Taking cognisance of learning in earlier adopter sites it is apparent that we need to recognise the readiness for change and how embedding additional staff in the practice processes leads to success. This is supported by the recruitment of a workforce with the relevant value set and skills, matching them appropriately with practices, taking an integrated MDT approach, while being able to support an evolving process and at each step sharing the learning, with a need to understand the roles and relevance of what each profession brings to the expanded MDT. This also requires risk sharing and delegation within practices.

Action 2019/20

Moving forward in 2019/20 there needs to be consideration of practice and Locality need, developing and maintaining the skills of people we already have and what they are learning. We also need to create time and space to have discussion, collaborative thinking and support in order to implement transparency and honesty while developing effective and efficient working tools and embedding them into practice.

This will require us to develop the 'offer' of a menu of support options for practices and clusters, covering both individual and team training and development needs, and in turn to have an 'ask' that practices and clusters work with us to help identify what those individual and team training and development needs might be and who/which practices and practitioner might need them.

Section 4: Requirements of New Guidance

4.1 Continuity of care

Continuity is one of the four Cs initially identified by Barbara Starfield and subsequently supported by the RCGP and others as being core to good general practice. The other three C's being Contact, Comprehensive, and Co-ordination.

Some have voiced concerns that the changes heralded by the 2018 GMS contract could have an adverse impact on continuity i.e. the focus on GPs as Expert Medical Generalists (EMGs) and the development of expanded MDTs could 'fragment' GP/patient relationships and in turn impact adversely on patient experience and on the use of specialist services – good continuity is related to lower use of specialist services, including the use of unscheduled specialist services.

In order to address these concerns it may be helpful to consider some wider contextual factors;

For some time now doctors have not been the exclusive providers of care continuity in practices. Instead supported by wider primary care from other independent contractors through practice attached to practice employed staff a whole range of other professionals have been meeting the care needs of patients in a GP practice supplemented by self-care, informal carers and local third and voluntary sector organisations.

By focusing on an EMG role, which includes complex care, undifferentiated illness and quality and leadership roles, GPs will be seeing patients of all ages, at all stages in their lives and indeed one of the key aims of the 2018 contract is that they (GPs and patients) will have more time to establish and develop those long term relationships that will be needed/utilised over those life stages.

We don't currently have, and probably never will have, enough GPs for them to be the ones to see/support every patient with every symptom or illness, nor could we justify the cost, even if there were enough GPs, that that would present to society.

On the other hand, we do have a whole range of professionals who can safely and appropriately support patients with care needs, freeing up GPs (and increasingly, relevant others) to spend more time with individuals when that is necessary e.g. when those individuals have complex or undifferentiated needs. Continuing to provide non-GP care with GPs when we don't have enough GPs not only adds to the unmanageable workload of GPs, thus impacting adversely on sustainability, but also undermines the roles and potential of the other professions to deliver the support that they can safely deliver to patients.

Taking steps to address the increasingly unsustainable workload and risks in primary care will also free up GP time for a role in improving continuity across the whole of the local health and social care system e.g. when GPs (as PQLs, CQLs, Clinical leads, GP sub members and CDs) are enabled to support that quality and leadership role it is expected that they will work across health and social care, in and out of hours, to ensure that patients' journeys are as seamless as possible.

This is an aspect of continuity of care that is wider than the continuity that is experienced within practices and possibly touches on elements of the other 3 Cs e.g. co-ordinate , contact (first) and comprehensive. It might also be thought of as expanding the original 4 Cs to include another 2 - coherence and connectedness of patient journeys– across the whole of the local health and social care system and across primary and secondary care.

Despite this it is clear that, almost by definition, if a patient is seeing someone other than a GP for care, even if that care is safely and appropriately provided by another, and the GP is then free to have more time with the patients that he/she really needs to see, that some patients may perceive that as a reduction in continuity. We therefore need to be aware of this risk and manage it appropriately.

Action 2019/20

During 2019/20 we will therefore promote the issue of continuity in discussions with CQLs and clusters to ensure that the investment from the Primary Care Improvement Fund is used in ways which optimises continuity of care whilst obtaining the full range of benefits of the new ways of working.

4.2 Local Workforce Planning

Workforce planning is one of the most significant challenges highlighted in the development and implementation of the Primary Care Improvement Plans, both in terms of availability of workforce at a sufficient scale to support all practices across GGC and in terms of the change process required to support effective working for new teams. In order to meet all requirements of the new contract and develop the MDT across all practices in Greater Glasgow and Clyde, an estimated additional workforce of between 800-1000 posts may be required.

Within the Board area HSCPs are committed to the following principles:

- Approaches across GGC should share consistent principles and pathways, role descriptors and grading, scale (numbers of staff per practice/ patient population)
- Recruitment should be co-ordinated across GGC where appropriate taking account of existing professional lead and hosting arrangements.

Across NHSGGC workforce planning for the Primary Care Improvement Plans is being considered in conjunction with the Board's wider Moving Forward Together strategy which sets a vision and direction for clinical services in the future. Staff Partnership representatives are involved at all levels. Specifically for the PCIPs, the key aspects of the approach include:

- Modelling to identify the work, tasks and skills required for the new roles
- Assessment of the numbers of staff required to fill those roles
- Modelling of the existing workforce including turnover
- Consideration of changes in other services and competing demands

- Reviewing different skill mix models and creative approaches to delivery both within and across professions.
- Developing approaches to supporting Multi-Disciplinary Team working within practices and between practices and wider community services

This approach is being tested initially within Pharmacy as one of the early priority areas, but will be adapted to other professional groups as part of year 2 and 3 implementation.

Work is underway in partnership with General Practice in transforming the roles of District, Community and General Practice Nursing. Nursing will play a key role in meeting the requirements of people with more complex health and care needs in a range of community settings to support people to stay longer at home and in their communities. This will build on current roles in prevention, early intervention, supported self-management, reducing inequalities and planning, providing, managing, monitoring and reviewing care.

The availability of key staff groups continues to require action at national level, particularly to ensure sufficient training places and development of skills for primary care.

The estimated recruitment targets for Glasgow City HSCP derived from the PCIP are included in the HSCP workforce plan. In total this amounts to a need to recruit around 450 additional wte staff to achieve full implementation. These estimates will be subject to continuing refinement. Securing an adequate, skilled workforce timeously, particularly pharmacotherapy and physiotherapy, represent one of the biggest challenges of fully implementing the PCIP within the timescale envisaged in the Memorandum of Understanding.

Table1. Workforce Projection for 2021-22 (wte) by Priority Workstream

Workstream Projection for 2021-22 (WTE) by Priority Workstream							
VTP	Pharma	Treatment	Urgent Care	MSK	MH	CLW	Total
32	90	193	21	51	25	41	456

In terms of local recruitment;

- We wish to avoid destabilizing core workforces like district nursing in the pursuit of recruitment of advanced roles. In fact this effect has been reported as adversely affecting other parts of the NHS system with the loss of pharmacists and ANP's to primary care from acute hospitals and pressure on community pharmacies from loss of staff.
- Need to consider growing our own staff, like technicians, in conjunction with local colleges
- Develop IT eHealth based solutions to reduce labour dependency
- Review different skills mix models

Action 2019/20

During 2019/20 we will consider service models in relation to staff numbers and skills mix to meet the requirements of the plan. We will also agreeing consistent approach to recruitment across the programme, exploring models with local colleges to provided identified workforce and monitoring impact of turnover on deliver.

4.3 Patient Engagement

Progress 2018/19

During 2018-19 we used the public partnership's participation and engagement infrastructure in each of the three Localities to raise the issue of the PCIP, its purpose and opportunities and to gauge reaction. This feedback contributed to the drafting of PCIP 1.

One of the key areas for development will be to engage with patients and carers about the changes they will see over the next few years in their GP practices. This requires an effective, joined up and consistent communication and engagement strategy that is planned and delivered at national, board wide, city, local and GP levels.

Action 2019/20

Over the course of 2019/20 we shall continue to use the Locality Engagement Forums as a means to continue this dialogue and further work with clusters to consider ways in which we can support GP practices to engage with their patients.

One patient group of particular interest is the views of people with complex and chronic conditions as their care needs can be the most challenging to manage and will provide the greatest test for joint working of GPs and the extended multi-disciplinary teams.

Beginning this financial year we will also extend this engagement specifically to include carers using the well-established mechanisms in the city and within Localities as well as linking with other city wide groups such as the Mental Health Network.

4.4 Infrastructure

4.4.1 Premises and Space Planning

The NHSGGC Property and Asset Management Strategy includes independent contractor owned and leased premises. Oversight of GP premises developments is provided through the Board's GMS Premises Group which reports to the overarching Primary Care Programme Board.

In year 1 of the PCIPs, existing mechanisms such as improvement grant funding have been used explicitly to support the requirement for additional space as part of PCIPs and this will continue.

There is a comprehensive programme of back scanning underway to free up space within practices to enable more clinical and administrative space to be provided, as well as supporting digital infrastructure through the removal of paper records.

The national survey of GP premises will report shortly and will be used to inform future planning and investment including prioritisation for premises improvement grants and planning for capital developments, and will also support the due diligence and impact assessment process where there is a request for the Board to consider taking on an existing lease or an option to purchase.

Specific challenges have been noted in ensuring sufficient accommodation for services within small practices, and also for services being provided in one location for several practices in a Locality. Supporting new developments to create additional space and accommodate Board employed staff is also challenging within independent contractor owned/ leased premises in line with the existing Premises Directions.

In the City there are 146 practices located in a combination of health centres and GP owned/leased premises. During consultation on our PCIP GPs expressed concern about the lack of both office and clinical space to provide accommodation for the development of MDTs and to develop community treatment and care services. However, the amount of capital funding made available to provide and or improve accommodation for the additional staff will be a major constraint on our ability to meet the conditions of the contract to locate staff within or near GP practices.

Progress 2018/19

During 2018/19 we took a number of actions to help us develop our plan:

- We highlighted in the HSCP property strategy the need for sufficient investment to upgrade premises to meet the requirements of the PCIP.
- When space becomes available in health centres we now investigate the potential for the accommodation to be set aside for the new staff.
- We issued a room usage questionnaire to all GPs who own/lease their premises and to our health centre managers to seek information on available space.
- Work stream leads are highlighting premises/space problems and identifying opportunities to use accommodation to support the PCIP implementation.
- We have agreed additional investment in a programme of back scanning of GP patient records with a first tranche of 15 practices to go ahead early in 2019/20.
- 23 sustainability loan agreements for practices in Glasgow are waiting final sign off by the Scottish Government and the BMA.
- 6 expressions of interest from practices seeking assignation of leases, 3 of which are in the same building.

- We issued letters to local GPs to offer them space in our future health and social care hub in north east Glasgow.

During years 2019/20 and 2020/21 there will be a further focus on strategic planning for primary care premises in the medium and long term, in the light of the new GP contract, Primary Care Improvement Plans and the wider context of Moving Forward Together (see 4.8) which sets out ambitions for the development of an extended range of community services based around virtual or actual community hubs. The strategy for GP premises will be developed in conjunction with the wider property strategy for community services and included within the capital plan associated with the Moving Forward Together programme.

Actions 2019/20

- Continuing to work with the Board and GPs to improve co-ordination of planning for premises to ensure suitable space is available for the new staff/services.
- Finalising our survey of room usage to identify any available space and to find out in more detail where there will be challenges in providing suitable accommodation.
- Maximising our available budget for minor works to upgrade buildings where this will be used to provide space for the new staff and clinical services.
- Continue to support the programme of back scanning.

4.4.2 Digital Infrastructure

Within NHSGGC, the eHealth team works in conjunction with HSCPs in the introduction of new services and processes within practices. This ensures where possible the standardisation of approach, fit to the Digital Strategy, use of core enterprise systems and minimal cost overhead. Costs have been supplied by eHealth to HSCPs to enable this to be incorporated into overall costs for new MDT members.

eHealth maintain an inventory of IT assets and software deployed to practices and for wider HSCP and Board operations. Development staff and eHealth joint working will ensure that as new services are deployed to support the MOU, and as significant estate changes occur (i.e. GP Practice back scanning of records, New Premises) that these are reflected in the introduction of new technology solutions and amendments to operational processes and Business As Usual working.

During GP engagement with the HSCP, GP's have fed back that a joined up IT system is vital for the success of the programme. Currently systems across GP practices and the HSCP do not support multi-disciplinary working and this is a priority to deliver on the programme.

Action 2019/20

During 2019/20 we will strengthen our links to the city and board eHealth groups to ensure primary care development needs are prioritised to support the development of MDT working and reduce reliance on staffing.

4.4.3 Data Sharing Agreements

The new GP contract introduced a joint data controller arrangement between Health Boards and GP Contractors relating to personal data contained within GP NHS patient records. Sharing of information between the people who are involved in the care of patients is increasingly important to the safe and effective delivery of health and social care, and to the delivery of services by the new Multi-Disciplinary Teams (MDT) working within and with practices. The PCIP plans for development of MDTs need to be supported by robust information sharing agreements with all practices for the delivery of clinical care, for audit and review purposes and for service, workforce and public health planning.

An information sharing agreement which lays out the rules to be applied by a Health Board and a GP Contractor when sharing information with each other is being developed nationally. This is a key enabler and is required as a matter of urgency to support the implementation of the PCIPs.

Action 2019/20

In 2019/20 we anticipate the sharing of the national data sharing agreement which we will require to review and agree implementation for the city supported by the data sharing officer resource to boards.

4.5 Funding

A major challenge is to manage the City's Primary Care Improvement Fund allocation fairly in ways that are equitable and transparent whilst recognising the scope for local discretion. To help ensure overall affordability, manage spend against the rising allocation and ensure financing of all the MoU priorities the Implementation Leadership Group has undertaken some preliminary financial forecasting.

In the first PCIP our preliminary estimates identified that our projected level of spend to deliver the full programme could breach the end point allocation. But we noted that this was still work in progress and that further work would follow to refine these costs. Following the completion of much further work many of the workstreams are considerably better developed in terms of service models, staff numbers and funding requirements. This is laid out in Appendix 5.3 and summarised below in Table 2.

Table 2. Projected Spend for PCIP Programme

Projected Spend					
£M	18/19	19/20 **	20/21**	21/22	Full Delivery
Allocation	5.529*	11.618	15.748	18.792	18.792
Planned Spend	2.574	9.164	16.870	20.367	22.931
Balance	2.025	2.454	-1.122	-1.575	-4.139

*£930k of funding held in Pharmacy Prescribing Support Unit in 2018/19

** Including carry forward from previous year

From Table 2 our concerns regarding the affordability of the programme identified in PCIP 1 have not receded. While the pattern fluctuates across the planning term the projected end point demonstrates that the financial allocation of £18.8m is insufficient to fund the full programme of commitments without significant compromise. In brief the position over the next three years is as follows

- We underspent in 2018/19.
- In 2019/20 we expect to underspend overall the full year Scottish Government allocation of £6.6m plus the carry forward of £2.1m from 2018/19 and the transformation fund of £2.9m
- The situation facing us in 2020/21 looks very different with the projections pointing towards an overspend if no corrective action is taken. This could include slowing down some or all of the workstream implementation programmes
- By 2021/22 the allocation continues to be overspent; while some workstreams are fully delivered by this point others will remain to be completed
- Full delivery will not be accomplished until after 2021/22 and will exceed the available allocation by £4.1m

Appendix 5.3 shows what that the end point of full delivery of the contract commitments is expected to be enabling investment across all of the contract commitments. This is summarised at Table 3 revealing that the total cost of full delivery of the contract commitment is likely to total £22.9m against the city allocation of £18.8m leaving a gap without further investment of £4.1m.

Table 3. Projected Full Delivery Allocations

Allocations									
Workstream	VTP	Pharma	Treatment Rooms	Urgent Care	MSK	MH	CLW	Other	Total
£m	2.5	5.5	6.4	1.1	2.5	2.0	2.2	0.64	22.9
%	11	24	28	5	11	9	10	3	100

The figures remain provisional and further work will be undertaken to depress costs where possible and to examine more cost effective means of delivery.

These estimates include the costs of the 6% uplift to superannuation at a minimum cost of £0.615m and could rise as plans develop. This highlights the need for additional funds to cover both this and pay uplifts which will be raised with the Scottish Government.

The solidity of the projection in Table 3 varies across the workstreams. City wide plans in areas like vaccination transformation programme, pharmacotherapy, community treatment services physiotherapy and community link workers are specified in some detail including staff numbers and funding (Appendix 5.2). We anticipate that these estimates will be refined to reflect the outcomes of discussions with CQLs and GPs in each of the Localities about their priorities.

For other areas like urgent care and mental health, the estimates are notional and we are looking to the Locality deliberations with CQLs and clusters to identify substantive proposals to deliver these particular priority workstreams. We would expect this to become clearer during 2019/20.

Faced with the currently projected deficits illustrated in Table 3 it is likely that the plan can only be delivered in balance, either before or after April 2021, if diluted across some or all of the workstreams. While this will balance the financial plan it will not meet GP expectations of the contract.

The Scottish Government is committed to engaging with GPs via their contract on the 'first' £250m ('in support of general practice), of an additional annual increase in a £500m total that was pledged to primary care, within the life of the current parliament. There has been little discussion on what the 'second' £250m would be used to resource, other than an agreement/understanding that it would be part of that £500m total that would go to primary care.

It could be anticipated that any further investment would go towards the cost of primary care commitments that are out with the 2018 GP contract e.g. the 800 additional GPs, and possibly the premises costs noted above. But if all of the 2018 commitments are to be realised in full then some consideration requires to be given as to whether some of any additional funding from the second primary care tranche should be directed to meet the anticipated PCIP shortfall. It is arguable that failing to do so could put GP and therefore primary care sustainability at significant risk.

The national local implementation tracker at Appendix 5.2 is designed to report on implementation, spending and recruitment for the Scottish Government every 6 months. For 2018/19 expenditure has been slower than anticipated and we are committed to accelerate progress during 2019/20. In terms of future years it is difficult to be absolutely certain on precise numbers of staff required as we are still in the midst of assessing the feasibility of redesigning service models, adjusting skill mix and embracing e-health solutions to reduce dependency on staff recruitment (see 4.2).

4.6 Inequalities

Though not a specific requirement of the Scottish Government's PCIP 2 guidance it was stated in the MoU that there is the opportunity to strengthen the role of general practice and primary care in mitigating inequalities and all PCIPs should address how services and service development will contribute to tackling health inequalities.

Progress 2018/19

For PCIP 1 there was a national requirement to consider the impact of inequalities within the plan and therefore this has been a key requirement of the devolved approach within the city to ensure that there is a fair and equitable distribution of resources and support across Localities as well as to clusters and practices. With that in mind advice has been taken from Finance, Public Health and the Centre for Population Health about the most appropriate allocation formula to adopt to allocate the PCIF monies across the city between the three Localities.

A series of options have been identified. The issues which primarily differentiate the various options are registered versus resident populations, the composition and degree of weighting given to the deprivation factor and the make-up of demand comprising GP workload. While NHS resources are customarily distributed through NRAC on the basis of resident population with a deprivation factor there is a view that within the city the eventual formula adopted should be more closely aligned to factors driving GP workload principally the number of patients and degree of illness, taking account of the effect of deprivation and poverty. A decision has yet to be taken on the selection of a specific formula.

Action 2019/20

Our priority will be to reach an agreement on the methodology for the distribution of resources to each Locality.

4.7 Evaluation

During 2018/19 work was undertaken across NHS GG&C on behalf of all six partnerships to develop a proposal to evaluate PCIP implementation.

The work in GCC is structured around six questions, using quantitative and qualitative methods, aimed at measuring the impact on GP workload, patient and professional satisfaction, better patient outcomes and navigation of new systems, improved equality and wider effect on health and social care.

Glasgow has committed £40,000 as its share of the total cost to support the development and delivery of this evaluation approach.

Action 2019/20

Within priority workstreams consideration is also being given to how to demonstrate the shifts in GP workload. In pharmacotherapy an audit tool has been developed for

use through negotiation to show the responsibilities being taken on by the new pharmacotherapists in terms of specific tasks and estimated direction and the consequent freeing up of GP time. We are looking to apply this approach to other priority workstreams in 2019/20.

4.8 Policy Integration

The Moving Forward Together (MFT) programme for Greater Glasgow and Clyde sets out a future vision for health and social care. This describes a whole system approach in which services are delivered by a network of integrated teams across primary, community and specialist and hospital based care. The MFT programme has been developed in parallel with the primary care improvement plans and builds on the direction of travel for the new GP contract, including the expert medical generalist role and the development of the multi-disciplinary team. MFT envisages the development of an enhanced community network, which goes well beyond the changes identified in PCIPs and describes some of the enablers and infrastructure required to support this. While there will be an opportunity to build on the foundation of the multi-disciplinary teams established through the PCIPs, the further detail and investment required for the enhanced community network will be developed as part of the next phase of MFT within work streams of planned care, unscheduled care, mental health and local care.

Section 5: Appendices

5.1 New Scottish Government Guidance

Primary Care Improvement Plans – Iteration 2 – 2019/2020 - Guidance Context

1. The National GMS Oversight Group comprises senior representatives of the four signatories to the Memorandum of Understanding on implementing the 2018 GMS contract: Scottish Government; British Medical Association; Integration Authorities and NHS Health Boards. The Oversight Group most recently met on 23rd January 2019, where it agreed the future reporting cycle of Primary Care Improvement Plans.
2. The first iteration of local Primary Care Improvement Plans were required to be shared with Scottish Government by end July 2018. These plans covered the period April 2018 to end March 2019. As we approach a new financial year, we expect all Integration Authorities to be creating the second iteration of these plans to cover the period April 2019 to end March 2020.
3. As stated in the 18th February 2019 letter from Richard Foggo, Head of Primary Care, Scottish Government, the second iteration of PCIPs should be drafted in collaboration with the GP Sub Committee and agreed with the relevant Integration Joint Board as soon as practicably possible after 1st April 2019. In addition, an agreed Local Implementation Tracker, covering the period July 2018 to March 2019 inclusive, is required to be completed collaboratively by local partners and shared with Scottish Government by 30th April 2019. All updated Primary Care Improvement Plans and Local Implementation Trackers should be developed and agreed by the relevant GP Sub Committee.

Memorandum of Understanding

4. The Memorandum of Understanding (MOU) effectively provided agreed guidance from the four parties of the Oversight Group to local partners for use in developing the first iteration of PCIPs. The core tenets of the MOU remain agreed and in place – in particular, that the development of primary care redesign in the context of delivery of the new GMS contract should accord with seven key principles to ensure that services are:

- Safe
- Person-Centred
- Equitable
- Outcome focussed
- Effective
- Sustainable
- Affordable

5. Importantly, the MOU also sets out an agreed understanding that the specific nature of implementation and related service redesign is required to reflect local

circumstances. No one size fits all. While the contract offer¹ and the MoU set out six key priorities for service redesign, the MOU states:

“Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources”.

6. This is relevant for all different geographies and communities across Scotland. For example, for remote and rural geographies, the contract offer states “in rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering ...services through locally agreed contract options”. We would expect to see evidence that options appraisals have taken place, and agreed with the local governance arrangements relating to primary care redesign, before this decision is taken.

7. Continuity is one of the core values of primary care as set out in the contract offer – this must be reflected in PCIPs to maximise continuity of care in establishing the new services and expanding the multidisciplinary team.

8. The second iteration of PCIPs should set out how local partners are ensuring continuity of care as implementation of the MOU progresses. In this context, it may be helpful to note the MOU states:

“The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices”.

Local Workforce Planning

9. The new Local Implementation Tracker will capture intelligence on a regular basis on local workforce recruitment activity and projections as the multidisciplinary team expands.

10. Effective workforce planning to enable primary care reform requires actions at national, regional and local levels. The forthcoming National Integrated Health and Social Care Workforce Plan will include proposed national actions building on the insight and intelligence provided by the first PCIPs.

11. The analysis of the first iteration of PCIPs found that the expression of local workforce planning approaches was generally weak across the plans and description of specific local actions and levers to increase workforce supply (including consideration of workforce skill mix) were generally absent from plans.

12. Plans to address workforce supply should be complemented by plans to address issues of workforce capability that go beyond those of professional competence. It is expected that these will consider the skills necessary to deliver successful user-led service redesign in a collaborative, multidisciplinary environment.

1 The 2018 General Medical Services Contract in Scotland.

<https://www.gov.scot/publications/2018-gms-contract-scotland/>

13. The second iteration of PCIPs are required to have clear sections on local actions related to workforce planning and supply and how potential gaps will be addressed.

Patient Engagement

14. Both the MOU and the Primary Care Improvement Fund allocation letter of 23 May 2018 stress the need for effective engagement of patients and service users as plans are developed. The MOU states:

“In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of the patient’s needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans”.

15. Analysis of the first iteration of PCIPs considered by the Oversight Group indicated that while there was evidence of strong engagement between HSCPs, Health Board professional leads, and the GP profession (in both co-producing and agreeing the plans) engagement with the wider public and patient engagement activities were less consistently evident across the first iteration of plans.

16. The second iteration of PCIPs should set out how local partners are ensuring that patient engagement is a key part of their plan.

Infrastructure

17. Both physical and digital infrastructure are key enablers of service redesign.

18. In relation to physical infrastructure specifically, all Health Boards are required under CEL 35 (2010)² to have Property and Asset Management Strategies. As well as covering NHS owned property, they are required to include other assets used for the delivery of NHS services such as property held by independent contractors and leased premises.

19. In relation to Primary Medical Services in particular, all Health Boards are required to “have in place a plan for the development of premises to support the provision of Primary Medical Services. This plan must be approved in consultation with the local Area Medical Committee. This plan should be updated annually and be consistent with the Health Board’s wider Property Strategy.”³

2 A Policy for Property and Asset Management in NHS Scotland CEL 35(2010) :
https://www.sehd.scot.nhs.uk/mels/CEL2010_35.pdf

3 Primary Medical Services – (Premises Development Grants, Improvement Grants And Premises Costs) Directions 2004, Direction 8 available at
www.sehd.scot.nhs.uk/gpweb/7/index7_dir.html

20. It is necessary for service plans to be developed in order for Health Boards to then plan the development of premises to support those services. Accordingly, Integration Authorities and Health Boards must work closely together in these planning processes.

21. In relation to digital infrastructure, the costs of supplying hardware and providing software licenses to additional staff to support primary care service re- design are core workforce costs that must be identified in PCIPs.

22. The second iteration of PCIPs should set-out what local processes are in place to identify both the physical and digital infrastructure needed to support Primary Care service re-design. They should also set out what resources are required locally for both physical and digital infrastructure.

23. The second iteration of PCIPs must demonstrate that Health Board's plans for the development of premises to support the provision of Primary Medical Services have taken account of the need to support Primary Care service re-design.

Funding

24. The analysis of the first iteration of PCIPs identified that 18 of the 31 IA areas included indicative funding profiles for more than one service priority for the initial three year period covered by the MOU. The analysis of in-year returns showed further refinement of expenditure profiles. The new Local Implementation Tracker will routinely capture PCIF spend and profiled expenditure against each of the six areas of service redesign. It is our expectation that all IAs will now be in a position to complete this element of the tracker in full.

Evaluation and understanding impact

25. The Primary Care Improvement Fund allocation letter of 23 May 2018 asked local partners to include in their PCIPs consideration of how changes will be evaluated locally.

26. The second iteration of PCIPs should include a description of how changes are being monitored and evaluated locally.

National GMS Oversight Group March 2019

5.2 National Local Implementation Tracker

Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as enablers required to deliver these. This tracker should be completed using a RAG system, and comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profiles tab** replaces the Template C returns that were provided to Scottish Government in 2018/19. These tables should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress. These tables will also support Integration Authorities in requesting the second tranche of the Primary Care Improvement Fund allocation in October 2019.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Tables 1 and 2. However, they should be included in Tables 3 and 4 to inform workforce planning

We would also ask that this local implementation tracker be updated and shared with Scottish Government by 30th April 2019 for the period July 2018 to March 2019 and by 30th October 2019 for the period April to September 2019.

**Primary Care Improvement Plans: Implementation Tracker DRAFT
NOVEMBER 2018**

Health Board Area: Greater Glasgow and Clyde

Health & Social Care Partnership: Glasgow City

Number of practices: 146

Completed

by:

HSCP/Board

**David
Walker
Pending**

**GP Sub
Committee**

Date:

Pending

15/05/19

Implementation period:

From: July 2018

To: March 2019

**fully in place
/ on target**

**partially in
place /
some
concerns**

**not in place /
not on target**

Notes for completion

	Overview (HSCP)			
to include consideration of relationships, involvement in ongoing structures and monitoring	MOU – Triumvirate enabled - GP Sub Engaged with Board / HSCPs	G	A	R
	Comment / supporting information	Engaging with the GP sub through ILG membership. Seeking to further develop at all levels		
	PCIP Agreed with GP Subcommittee	G	A	R
	Comment / supporting information (date of latest agreement)	Meeting on 15/5/19 to agree plan		
	Transparency of PCIF commitments, spend and associated funding	G	A	R
	Comment / supporting information	Reported regularly to ILG with spend by agreement		

Primary Care Support to complete	Enablers / contract commitments			
	BOARD			
	Premises			
	GP Owned Premises: Sustainability loans supported	G	A	A
	comment / supporting information	Applications	No.	51 (GCHCSP 23)
		Loans approved	No.	51 provisional
		narrative:	Funding available for all applications subject to finalisation of loan agreement	
	GP Leased Premises: Register and process in place	G	A	R
	comment / supporting information	Applications	No.	17 (6 GCHSCP)
<i>tbc additional question on implementation of other processes as per new regulations, e.g. list closure, area change, disputes</i>		Leases transferred	No.	0
		narrative:	Process for developing the register under development: 17 expressions of interest from practices seeking assignation of lease.	
	Stability agreement adhered to	G	A	R
	comment / supporting information	Enhanced Services agreed annual in line with stability agreement; local arrangements developed in relation to vaccination prior to national guidance. Some concerns expressed about changes to wider community services (e.g. Sandyford)		
	GP Subcommittee input funded	G	A	R

	comment / supporting information	Additional sessions and HSCP reps funded in 18/19 to support new contract and PCIP processes, in addition to core GP Subcommittee funding. Final agreement re balance of new 18/19 funding still to be confirmed. Move to a more standardised approach in 19/20 supported by new funding in the process of being finalised.		
	Data Sharing Agreement in Place	G	A	R
	comment / supporting information	Awaiting national data sharing agreement. This is required as a matter of urgency to support local agreements.		
	HSCP			
	Programme and project management support in place	G	A	R
	comment / supporting info	Programme manager, Admin support and PCDO's in post		
	Support to practices for MDT development and leadership	G	A	R
	comment / supporting info	Engaging with practices, clusters and Localities to understand their needs. Development of Collaborative leadership and learning workstream to support MDT working		
	GPs established as leaders of extended MDT	G	A	R
	comment / supporting info	Building on existing strengths		
	Workforce Plan reflects PCIPs	G	A	R
	comment / supporting info	Recognised in HSCP workforce plans. Collegiate arrangement with other 5 HSCPs in the Board area. Ongoing review of workforce need in response to tests of change and impact on MoU priorities.		
<i>consider adding question on long term</i>	Accommodation identified for new MDT	G	A	R

<i>strategic plan for primary care premises</i>	comment / supporting info	Back scanning for all practices and reviewing accommodation within HSCP estate and other providers. Progress could be delayed due to lack of availability of appropriate space.		
	GP Clusters supported in Quality Improvement role	G	A	R
	comment / supporting info	Led by Localities in Glasgow		
	EHealth and system support for new MDT working	G	A	R
	comment / supporting info	Hindered by slow rate of national progress on key issues		
	MOU PRIORITIES			
	Pharmacotherapy			
	PCIP pharmacotherapy plans meet contract commitment	G	A	R
	Pharmacotherapy implementation on track vs PCIP commitment	G	A	R
	Practices with PSP service in place	43		
	WTE/1,000 patients	0.4/5000 weighted population implementation ratio		
	Pharmacist Independent Prescribers (as % of total)	80% of all pharmacists		
		Level 1	Level 2	Level 3
	Level of Service	yes	yes	Yes
	comment / narrative	Contract workload prioritisation has been varied by local practice agreement. Slow recruitment based on available supply.		
	Community Treatment and Care Services			
	PCIP CTS plans meet contract commitment	G	A	R
	Development of CTS on schedule vs PCIP	G	A	R
	Practices with access to phlebotomy service	No. practices - 58 Practices		
	Practices with access to CTS service	No. practices - 58 Practices		
	Range of services in CTS	Full range as per MoU		

	comment / narrative	Challenge to provide for patients in smaller practices.		
	Vaccine transformation Program			
	PCIP VTP plans meet contract commitment	G	A	R
	VTP on schedule vs PCIP	G	A	R
	<i>Pre-school:</i> model agreed	G	A	R
	practices covered by service	146		
	<i>School age:</i> model agreed	G	A	R
	practices covered by service	146		
	<i>out of schedule:</i> model agreed	G	A	R
	practices covered by service	No. practices - NA		
	<i>Adult imms:</i> model agreed	G	A	R
	practices covered by service	Implementation in 2019/20 with ongoing monitor and review		
	<i>Adult Flu:</i> model agreed	G	A	R
	practices covered by service	Plans for 2019/20. Under 65 area challenges		
	<i>Pregnancy:</i> model agreed	G	A	R
	practices covered by service	To be implemented by Maternity Service in 2019/20		
	<i>Travel:</i> model agreed	G	A	R
	practices covered by service	0		
	comment / narrative	Dependant on national appraisal lead by HPS.		
	Urgent Care Services			
	Development of Urgent Care Services on schedule vs PCIP	G	A	R
	practices supported with Urgent Care Service	0		
	comment / narrative	Implemented preferred model of local GPs to cover residential care . ANP posts in residential care operational from April 2019 following inductions.		
	Additional Services (complete where relevant)			

	APS – Physiotherapy / MSK			
	Development of APP roles on track vs PCIP	G	A	R
	Practices accessing APP	13		
	WTE/1,000 patients	0.33wte / 14,000-16,000 population		
	comment / narrative	Slow process of recruitment based on available supply		
	Mental health workers			
	On track vs PCIP	G	A	R
	Practices accessing MH workers / support	0		
* ref to Action 15 where appropriate	WTE/1,000 patients	TBC		
	comment / narrative	Reviewing pathways and locally considering further options for greatest impact set against complex landscape of both in / out of hours.		
	APS – Community Links Workers			
	On track vs PCIP	G	A	R
	Practices accessing Link workers	18		
	WTE/1,000 patients	TBC		
	comment / narrative	Plans to expand to 35 in 2019/20 to support practices with deprived patient population		
	Other locally agreed services (insert details)			
	Service - Occupational Therapy			
	On track vs PCIP	G	A	R
	practices accessing service	0		
	comment / narrative	Model to be considered and possible testing 2019/20		

	Overall assessment of progress against PCIP		A	
	Specific Risks			
	<p>Time needed for engagement with GPs and others balanced against pressure to accelerate spend. Providing quantifiable evidence of impact of additional services in reducing GP workload and benefiting patients. Responding adequately to effects of deprivation on GP workload. Maintaining sustainably of GP practices.</p>			
	Barriers to Progress			
include interdependencies indicate if local or national	<p>Availability of key skilled staff, ANPs, APPs and Pharmacists with competition between HSCP and Practices. Digital solutions to support PCIP. Lack of data sharing agreement. Loss of GP attrition and succession planning across tripartite arrangements. Availability of appropriate accommodation.</p>			
	Issues FAO National Oversight Group			
	<p>National workforce planning, recruitment and training. Digital and data sharing solutions. Desire for local flexibility within the MoU parameter to provide GP input for local flexibility. Candour in the above with SGPC that fulfilment of plans will at present rate overshoot plan period (2020/21) and financial allocations. No financial support to cover staff pay uplifts and superannuation costs. Accommodation availability and funding process for GP practices through improvement grants. Affordability of delivering on the full programme.</p>			

Funding and Workforce profile

Table 1: Spending profile 2018 - 2022 (£s)

Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	112		485		605		2		712	191	467	
2019-20 planned spend	1064		1769		1296	418	242		1828	1200	1347	
2020-21 planned spend	2458		2590		4949	179	267		2559	1835	2033	
2021-22 planned spend	2542		2779		6185	179	1136		3304	2089	2153	
Total planned spend	6176	0	7623	0	13035	776	1647	0	8403	5315	6000	0

Table 2: Source of funding 2018 - 2022 (£s)

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche 2 funding held by SG
2018-19	2574			
2019-20	9164	2946	6647	
2020-21	16870	2454	13294	
2021-22	20367		18792	
Total	48975	5400	38733	0

Funding sources for 19/20 will include £2.946m Primary Care Transformation Fund monies have been carried forward. Based on our current projections full delivery of the plan will not be achieved until after 2021/22 at a total cost of £22.9m exceeding the final year allocation of £18.8m by £4.1m. Similar applies also to workforce where projected full delivery is at 456 additional staff. Further financial pressure emerging from staff pay uplifts and superannuation costs.

Table 3: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	19	4	2	14	0	0	0	0	2	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	24	3	0	0	0	1	0	0	2	7	5	17
PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
TOTAL headcount staff in post by 31 March 2022	43	7	2	0	0	1	0	0	4	7	5	17

[a] please specify workforce types in the comment field below

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 4: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL WTE staff in post as at 31 March 2018	15.3	3.4	1.0	11.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	15.6	2.2	0.0	0.0	0.0	1.0	0.0		2.0	7.0	5.0	17
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	12.4	6.0	24.0	35.0	8.0	2.6	0.0		TBC	5.0	1.0	18
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	9.0	6.0	10.0	44.0	11.0	0.0	0.0		TBC	5.0	2.0	6
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	TBC	TBC	6.0	16.0	0.0	17.4	0.0		TBC	5.0	TBC	0
TOTAL WTE staff in post by 31 March 2022	52.3	17.6	41.0	106.0	19.0	21.0	0.0	0.0	4.0	22.0	8.0	41.0

[a] please specify workforce types in the comment field

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comments: Vaccination coordinated on board wide basis with wte still to be confirmed.
 PCIP models a ration of 2:1 pharmacist to technicians. Test of change to identify the task deliverable by technician resource is ongoing which will inform this model going forward.

5.3 Finaical Plan

Primary Care Improvement Fund	19/20 Planned Expenditure	20/21 Planned Expenditure	21/22 Planned Expenditure	Full Delivery Cost
Priority Workstreams				
Vaccination Transformation Programme	1,064	2,458	2,542	2,550
Pharmacotherapy	1,769	2,590	2,779	5,500
Community Treatment and Care	1,714	5,128	6,363	6,400
Urgent Care	242	267	1,136	1,136
Community Link Workers	1,347	2,033	2,153	2,200
Mental Health	881	1,006	1,350	2,000
Advanced Practice Physios	556	1,013	1,311	2,500
Occupational Therapy	26	168	264	264
Enabling Workstreams				
Sustainability	50	100	100	100
Cluster Support	281	281	281	281
Project Team	301	307	313	
Collaborative Leadership and Learning	317	320	324	
Premises	470	1,050	1,300	
Total Estimated Costs	9,018	16,721	20,216	22,931
Primary Care Transformation Fund Projects Carried Forward	146	149	151	
Total	9,164	16,870	20,367	22,931
Funding				
SG	6,647			
PCTF	2,783			
PCIP carry forward 18/19	2,025			
Total funding	11,455	13,294	18,792	18,792
Balance	2,291	-3,576	-1,575	-4,139

Primary Care Improvement Fund	In post as at 31/3/19	In post as at 31/3/20	In post as at 31/3/21	In post as at 31/3/22	Full Delivery
<u>Priority Workstreams</u>					
Vaccination Transformation Programme	tbc	tbc	tbc	tbc	32.00
Pharmacotherapy	36.50	54.90	69.90	69.90	90.00
Community Treatment and Care	12.00	79.00	144.00	166.00	193.00
Urgent Care	1.00	3.60	3.60	21.00	21.00
Community Link Workers	17.00	35.00	35.00	41.00	41.00
Mental Health	2.00	2.00	2.00	2.00	25.00
Advanced Practice Physios	7.00	12.00	17.00	22.00	51.00
Occupational Therapy	0.00	1.00	3.00	3.00	3.00
<u>Enabling Workstreams</u>					
Project Team	5.00	5.00	5.00	5.00	
<u>Primary Care Transformation Fund Projects Carried Forward</u>					
PH4MH	2.00	2.00	2.00	2.00	
Total funding	82.50	194.50	281.50	331.90	456.00